PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM

ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

FISCAL YEAR: FY 2003

STATE: Virginia

NAME OF P&A SYSTEM: Virginia Office for Protection and Advocacy

NAME OF PAIMI PROGRAM (If Different): N/A

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SECTION I. PAIMI PROGRAM GENERAL INFORMATION

A. Description of Protection and Advocacy (P&A) System PAIMI Program:

1. Name of PAIMI Coordinator: **Jonathan G. Martinis, Esq.**

2. Name and Address of designated P&A System:

   a. Main office: **Virginia Office for Protection and Advocacy**
   202 N. 9th Street, 9th Floor
   Richmond, VA 23219

3. Satellite offices: **Virginia Office for Protection and Advocacy**
   114 MacTanly Place
   Staunton, VA 24401

   Virginia Office for Protection and Advocacy
   287 Independence Boulevard, Suite 120
   Virginia Beach, VA 23462

B. Governing Board, Advisory Council and PAIMI Staff (on 9/30):

1. Does the P&A have a multi-member governing board? Yes **X** No __

2. Is the Chair of the PAIMI Advisory Council a member? Yes __ No **X**
   (If No, please explain.) The PAIMI Advisory Council Chair is an ex-officio, non-voting member of the Governing Board. As a state agency, there is no requirement that the PAIMI Advisory Chair be a member of the Board.

3. Provide the number for the Advisory Council and the Governing Board as requested in the table below. Indicate the one primary identification of each member as of 9/30. Count each member only once.

	Advisory Council	Governing Board
Total Number of Members on 9/30 of Fiscal Year	12	11
Term of Appointment (Number of years)	4	4 (Original Board members were appointed in staggered terms of 2,3,4 years)
Number of Terms a Member Can Serve	1	2 (consecutively)
Frequency of Meetings	Quarterly	Quarterly and As Needed
Number of Meetings Held in the Fiscal Year	4	5
% (Average) of Members Present at Meetings	51%	87%
Recipients/Former Recipients (R/FR) of Mental Health Services	4	*
Family Members of R/FR of Mental Health Services	3	*

Mental Health Professionals	2	
Mental Health Service Providers	0	
Attorneys	2	
Individuals From the Public Knowledgeable About Mental Illness	1	
Other Persons Who Broadly Represent or Are Knowledgeable About the Needs of Mentally Ill Individuals		*
TOTAL	12	11

* Governing Board members are not required to disclose whether they are recipients/former recipients of mental health services. Three Board members have identified themselves as having a disability; two of which have received mental health services. Board members are also not required to disclose if they have a family member who is a recipient/former recipient of mental health services. However, five board members have identified that they have a family member receiving/or has received disability-related services.

4. Does the P&A program utilize volunteers? No

5. Are PAIMI services and activities to individuals with mental illness and their families supported by funding other than that provided by Federal dollars or P&A program income? Yes /**X/** No / /

   A very limited number of individuals that are dually diagnosed with a mental illness and another disability may be served under other funding streams; however, this is very rare.

C. PAIMI Program Staff

1. Provide the total of staff paid either partially or totally with PAIMI funds or from P&A program income: **11**
   a. Of the above total, how many staff are attorneys? **4**
   b. Of the above total, how many are non-attorney case workers? **3**

Ethnicity/Race	Staff	Advisory Council	Governing Board
American Indian or Alaska Native	0		0
Asian	0		1
Black or African American	1	1	0
Hispanic or Latino	0		0
Native Hawaiian/Other Pacific Islander	0		0
White	10	11	10
Vacancies as of 9/30	0	0	0

Gender			
Male	4	6	4
Female	7	5	7
Total	11	12	11

SECTION II. PAIMI PROGRAM PRIORITIES and DESIRED OUTCOMES

Below, list PAIMI program priorities and objectives that were the targets of this fiscal year's program activities. For each priority, provide an example of an individual or systemic case and, if applicable, a legislative activity. Please include examples of PAIMI Program participation in State mental health planning activities. Remember case examples should illustrate the impact and/or disposition of PAIMI program efforts.

Priority 1: Abuse and Neglect in State-Operated and Community-Based Facilities

GOAL 1: To represent the interests of individuals who are subjected to abuse or neglect as defined in the Priority.

Indicator was: **X** Met /_/Partially Met/Continuing /_/Not Met

1. VOPA investigated the neglect of SH, a man with Bipolar Disorder, who complained to VOPA that he suffered neglect by the Danville-Pittsylvania Community Services Board (DPCSB), the local public mental health service provider in his area. SH alleged that DPCSB incorrectly found that he did not have Bipolar Disorder, improperly withdrew his antipsychotic medication, and did not adequately supervise its doctors. VOPA did a comprehensive investigation including the review of over one thousand pages of records, interviews with a dozen witnesses, and the receipt and review of two expert reports. After reviewing the entire matter, VOPA concluded that DPCSB had neglected SH. VOPA provided a draft report of its findings to DPCSB giving the opportunity to comment on the report. Rather than comment, DPCSB sued VOPA in an attempt to prevent the report from being made public. VOPA contested the suit, leading to DPCSB dismissing its own Complaint. The report was published. As of the present date, SH is living in the community and being served, successfully, by a different Community Services Board. As a result of the report, DPCSB has made changes in the way it treats its clients and the way it supervises its doctors.

2. S, a male patient at a state operated mental health institution, asked for VOPA assistance when a nurse employed at the institution cursed and insulted him in the presence of at least one other patient. The male patient expressed feelings of humiliation, degradation and embarrassment because of the incident. S told VOPA staff he wanted the nurse to improve her attitude and her treatment of patients, but he did not want her fired. The VOPA staff investigated the incident and worked with the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and institution representatives to resolve the patient's complaint. The matter was handled through the employee discipline process, and a written notice alleging a Standards of Conduct violation was issued against the nurse. The Standards of Conduct violation was upheld through the nurse's appeal. Since that time, S and several other patients have regularly reported the nurse's conduct to the VOPA staff. Based on these reports, it appears that the nurse's attitude and conduct have taken a dramatic turn for the better, and there have been no more rude or abusive incidents. The male patient has expressed complete satisfaction with the services VOPA provided him in this matter.

3. L, a male patient of a state mental health institution, approached VOPA staff during a rights clinic being conducted by VOPA staff at the institution. Displaying large open sores covering large areas of both of his feet, he asked the VOPA staff to help him obtain treatment for the sores. L explained that he had developed the sores by walking a long distance in ill-fitting shoes before being involuntarily committed and brought to the institution, but that the sores had not been treated since he arrived. The VOPA staff immediately confronted the charge nurse for L's unit. The nurse apologized, promised to have L's feet treated without delay, and in fact did so within 10 minutes. Although L expressed gratitude to the VOPA staff for helping him obtain medical treatment, L was not willing to sign a records and information release or proceed with a neglect investigation.

4. The family of TT, a young man with severe depressive and anxiety disorders, requested VOPA's assistance when TT was incarcerated and the jail personnel refused to provide him with his medication. The VOPA staff informed the jail administrators that their actions appeared to be in violation of a number of state and federal laws and regulations. When this failed to obtain the medication, VOPA staff required the Jail Administration to bring TT to a nearby mental health clinic for an emergency mental health evaluation. VOPA staff arranged for the psychiatrist who had originally prescribed TT's medication to conduct the evaluation, and she promptly ordered the jail to dispense TT's medications as prescribed. Once TT was back on his medications, his condition began improving right away. A few days later, however, a family member called VOPA to report that, although the jail staff were dispensing TT's scheduled medications as prescribed, they had told him that he would be put into segregation if he asked for his "prn" (medication prescribed on as "as needed" basis). VOPA promptly intervened. The jail rescinded the condition, and TT received his prn medication without fear of being placed into segregation.

GOAL 2: To increase the awareness of facility patients, their families, and facility staff of VOPA services and legal rights through outreach, technical assistance, and training activities.

Indicator was: **X** Met / /Partially Met/Continuing / /Not Met

1. VOPA staff routinely provide outreach at all state-operated mental health institutions.

2. VOPA staff routinely attend Local Human Rights Committee* (LHRC) meetings at selected providers.

   * A group of volunteers from a designated locality who meet regularly to review provider policies that affect consumers, conduct fact-finding hearings in cases where a consumer has alleged a violation of his/her rights, and conduct reviews of capacity as it relates to ECT and appointment of legally authorized representatives. The group consists of consumers, family members of consumers, professionals, and other interested individuals. They are the quasi-judicial enforcement entity for the DMHMRSAS Human Rights regulations.

3. VOPA staff were presenters at two continuing education courses attended by more than 350 mental health professionals from a variety of mental health settings including community services boards, state mental health institutions, general hospitals, and private clinics. The seminar, entitled "Virginia Mental Health and the Law," was a continuing education course approved by the Association of Social Work Boards, American Psychological Association, National Board for Certified Counselors, American Nurses Credentialing Centers Commission on Accreditation, American Health Information Management Association and Commission for Case Management Certification.

4. VOPA staff provided training to 16 staff at a day program for individuals with disabilities. The training consisted of general information about VOPA and the newly enacted Department of Mental Health, Mental Retardation and Substance Abuse Services' Human Rights Regulations.

5. VOPA staff provided an overview of VOPA services and participated in a panel discussion entitled "A Move Toward Community-Based Services" sponsored by the civic organization Prince William County Committee of 100.

6. VOPA staff presented a general overview of VOPA services to members of a state mental health institution's Advisory Council.

7. VOPA staff conducted 123 impromptu on-unit/location patient outreach activities at state mental health institutions. It should be noted that some of these are on the wards of the institutions, while others are conducted in day rooms, conference rooms, etc. They may or may not be coordinated with/by the institution representatives.

8. VOPA staff distributed over 8900 copies of VOPA publications to institutions pursuant to negotiated agreements for them to use the publications in employee training and/or patient group therapy sessions, to distribute the publications to patients (upon admission), staff, guardians, and legally authorized representatives, and/or to maintain displays of the publications in lobbies and other public places.

9. VOPA staff conducted 30 on-location outreach visits to community programs and facilities.

10. VOPA staff distributed over 1500 copies of VOPA publications/posters/promotional items to Community Services Boards, community programs and facilities, and other community-based programs which established displays or distribution agreements, and did not previously display or use VOPA materials.

11. VOPA staff conducted eight (8) outreach activities with consumer/family organizations including National Alliance for the Mentally Ill affiliates, the Mental Health Association, and "clubhouses" (psychosocial rehabilitation providers).

12. VOPA staff distributed over 400 pieces of VOPA literature to consumer/family organizations.

13. VOPA staff organized and conducted a mass mailing of VOPA literature and posters to community facilities in Southside Virginia, planned a follow-up visit program to assure that the mailed materials were properly posted/displayed, and made unannounced visits to 21 community facilities. All of these facilities were either in compliance when visited, or were brought into compliance at that time.

Priority 2: Community-Based Services in the Most Integrated Setting

GOAL 1: To ensure that adults and juveniles ready for discharge from public or private residential facilities are discharged to the community with appropriate services and supports.

Indicator was: **X** Met /_/Partially Met/Continuing /_/Not Met

1. VOPA represents LC, an individual with mental illness who had been found Not Guilty By Reason of Insanity (NGRI) of a misdemeanor. LC was sent to a state mental health institution and spent nine years there. In the interim, Virginia passed a law stating that people found NGRI of misdemeanors could spend no more than one year in forensic custody. VOPA learned of LC through the National Alliance for the Mentally Ill. VOPA contacted LC, who requested VOPA's advocacy services. VOPA filed a motion for LC's release, pursuant to a discharge plan developed by Department of Mental Health, Mental Retardation, and Substance Abuse Services. The Commonwealth Attorney of the City of Norfolk opposed the discharge. After legal argument, the Court held that LC should be discharged. He is currently living successfully in the community.

2. VOPA helped BB, a young male patient of a state mental health institution, to have his wishes respected in the discharge planning process. BB asked VOPA for assistance after BB's case manager (an employee of the local community services board responsible for discharge planning with patients) refused to plan for BB to return to his pre-hospitalization placement after discharge. VOPA confirmed that the placement BB requested was clinically appropriate to his needs. VOPA then addressed the problem by educating and supporting BB's treatment team's effort to pursue respectful discharge planning. VOPA negotiated an informal case specific monitoring agreement, about BB's discharge plan and any changes to it, with an administrator of the institution. BB was subsequently discharged to his desired placement and is currently living successfully in the community.

3. A patient of a state mental health institution told VOPA she had required frequent hospitalizations because of her inability to obtain adequate post-discharge case management services. VOPA determined that the community services board's (CSB) refusal to provide cases management services to this patient was based on their rigid interpretation of CSB eligibility guidelines. VOPA worked with the CSB to have the patient reassessed and her eligibility for case management services re-examined. When this process was completed, the patient was approved for the desired services and a case manager was assigned. At last report, the patient was living successfully in the community.

GOAL 2: To ensure that adults and juveniles who have been discharged from an in-patient psychiatric setting to the community, who are at risk of reinstitutionalization, have access to appropriate services and supports in the most integrated setting.

Indicator was: **X** Met /_/Partially Met/Continuing /_/Not Met

1. A male patient (FW) was discharged from a state mental health institution pursuant to a rather complex discharge plan, which was designed to help him avoid frequent re-hospitalizations. One of the supports provided in the plan required FW to travel some distance each day to attend an appropriate day treatment program. Soon after FW

was discharged, it was discovered that no funding had been arranged to provide the necessary transportation between his residential placement and the day treatment program (in an adjacent county). The local Department of Social Services (DSS) told relatives it would take 45 days to process a funding application, and refused to expedite the application despite the circumstances. Frustrated, a relative contacted VOPA for assistance. VOPA took the matter up with the local DSS eligibility department, and ultimately with its director. The funding application was subsequently expedited, and FW began receiving transportation services about one week after VOPA became involved. At last report, FW was living successfully in the community.

2. This case arose when a state mental health institution appointed an out-of-state parent as an adult patient's legally authorized representative (LAR) after HQ and the in-state parent refused to go along with the institution's treatment and placement recommendations. As the LAR, the out-of-state parent approved recommended medications and congregate residential placement, and prevented the in-state parent from obtaining records or information concerning HQ's treatment and discharge plans. HQ was discharged to a congregate residential placement, which he promptly left, to return to live in his home with the support and assistance of the in-state parent, who lived nearby. HQ asked VOPA for advice to ensure that the in-state parent would be responsible for his treatment and placement decisions during periods of incapacity. VOPA discussed the client's needs and wishes and then advised him regarding his rights. Based on this discussion, an appropriate Advance Medical Directive/Durable Power of Attorney was developed to prevent future abuses of his right to self-determination.

GOAL 3: To participate in and contribute legal expertise and consultation to the state Olmstead Task Force for the purpose of facilitating the creation of an appropriate and comprehensive "Olmstead Plan" to ensure that persons with mental illness receive appropriate supports and services in the most integrated setting.

Indicator was: **X** Met /_/Partially Met/Continuing /_/Not Met

The Olmstead Task Force completed its year-long work by releasing a comprehensive Report recommending that the Commonwealth take concrete and bold steps to ensure that people with disabilities are empowered to live in the most integrated setting. VOPA served in a leadership capacity on the Task Force, serving as agency convener to two (out of the seven) issue teams, serving as liaison to a third team, and serving on the twenty-member steering committee. VOPA also offered several amendments to the draft final plan, most of which were accepted, resulting in a more streamlined, more effective plan.

Priority 3: Deaths and Critical Incidents in State Mental Health Facilities and Community-Based Facilities

GOAL 1: To ensure that incidents of abuse and neglect are properly reported and investigated and that facilities take appropriate remedial action in instances of abuse or neglect.

Indicator was: **X** Met /_/Partially Met/Continuing /_/Not Met

1. A preliminary inquiry was conducted about inappropriate touching, kissing, and other physical contact with a female patient (MN) by a male employee of a state mental health institution. An investigation conducted by the institution substantiated the patient's allegations. The investigation raised issues of whether appropriate safeguards are in place to prevent circumstances where an employee has the opportunity to exploit a patient. The report also raised concerns whether appropriate action was taken when a supervisor noted that the male employee was engaging in inappropriate interaction with the female patient. The institution' s investigation report contained recommendations for measures aimed at ensuring that staff do not have opportunities for inappropriate contact with patients. These recommendations were implemented. VOPA determined that the facility took the appropriate action in this case.

2. A preliminary inquiry was conducted as a result of VOPA receiving a complaint about medication services provided by the Program of Assertive Community Treatment (PACT) team of the local Community Services Board (CSB). The anonymous complaint alleged, among other things, that: medications were not being given on time; appropriate procedures for refused medications were not being followed; medication errors were not being appropriately documented; medications were being taken home by staff/medications were not being properly secured; tests for blood levels of lithium, carbamazepine, valporic acid, clozapine were not routinely being done; and that the negligence of nursing staff contributed toward the death of a client. VOPA conducted an interview of

the PACT team supervisor and reviewed a random sample of PACT team client records. DMHMRSAS Licensing conducted an investigation into this complaint. As a result of VOPA's preliminary inquiry, the Community Services Board developed and implemented a corrective action plan. VOPA determined that appropriate corrective action was taken.

3. The Code of Virginia requires that deaths and certain defined critical incidents in state mental health institutions be reported to VOPA within designated timeframes. Based on the content of the critical incident report (CIR), VOPA may take varying steps. This will always be an on-going effort for VOPA as it is a state required activity. During FY 2003, there were 645 critical incidents reported to VOPA from state mental health institutions. Of those, ten were opened for preliminary inquiry. Eight were closed with no further action required and two were elevated to full investigations.

GOAL 2: To improve the safety of DMHMRSAS facility residents by determining whether there are patterns or trends contributing to a disproportionate number of critical incidents at DMHMRSAS-operated mental health facilities.

Indicator was: **X** Met /**X**/Partially Met/Continuing /_/Not Met

The DMHMRSAS met with their facility risk managers to more accurately report critical incidents among facilities. This resulted in an increase in the number of CIRs reported to VOPA during the fiscal year. It was noted, after discussion with DMHMRSAS officials that although there was an increase in CIRs reported, there was more uniformity in reporting. VOPA quarterly analysis of the CIRs did not reflect any patterns or trends that might conclusively lead to the increase.

GOAL 3: To improve the safety of patients of community-based facilities by beginning to assess extension of the critical incident notification system to community-based facilities through future legislative action.

Indicator was: **X** Met /**X**/Partially Met/Continuing /_/Not Met

1. VOPA continues to analyze its critical incident reports system and reports (some were also received from some community-based providers) in an attempt to assess whether it would be practical to extend the CIR requirements to community-based providers. The VOPA Board of Directors has established an ad hoc committee to explore the extension of the reporting system to include requiring community based providers.

2. VOPA enforced reporting requirements by Psychiatric Residential Treatment Facilities (PRTFs) and received several reports of patient injuries.

Priority 4: Informed Consent to Treatment

GOAL 1: To represent the interests of persons who have been treated in the absence of or contrary to informed personal consent or that of a properly authorized substitute decision-maker.

Indicator was: **X** Met /_/Partially Met/Continuing /_/Not Met

1. VOPA represented a woman who had been admitted, pursuant to a Temporary Detention Order, to a private hospital. The woman complained to VOPA that she was being medicated over her objection. VOPA informed the hospital that it was improperly and illegally forcibly medicating the woman. The hospital originally claimed that it had a right to do so. VOPA then informed the hospital that it would file suit to enjoin it from forcibly medicating the woman. The hospital then agreed not to forcibly medicate her.

2. A patient of a state mental health institution requested VOPA's assistance to resolve medication issues including being forced to take medication over her objection and in spite of negative side effects stemming from the use of the medication in question. The patient's legally authorized representative (LAR) reported to VOPA that the patient's present psychiatrist, as well as the preceding psychiatrist, had been forcing the patient to take the offending medication for at least six months. The LAR also told VOPA she had joined with the patient in asking the hospital to change the patient's medication, but that their request had been ignored. VOPA reviewed the

patient's chart, and then advised her and her LAR that they had proper grounds to sue for deprivation of civil and constitutional rights. Despite the patient's strong legal position, she and her LAR advised VOPA that they were unwilling to sue, except as a last resort. VOPA obtained the following relief in the case: (1) the patient was transferred to another state mental health institution, which was two hours closer to the area where her family lived; (2) the offending medication was discontinued, with no apparent lasting after-effects; (3) the patient and her LAR worked closely with the treatment team at the new institution to develop a treatment plan that incorporated the patient's preferences; (4) the charts of all institution patients were reviewed to detect and correct any informed consent deficiencies affecting other patients; (5) of the two psychiatrists who wrote orders for the patient to be medicated in the absence of informed consent, one resigned and the other was appropriately disciplined; (6) the institution's "consent to medication" form and LAR forms* were revised to clearly inform patients and LARs of their treatment-related rights, including the right to refuse a particular treatment; (7) institution procedures were revised to require special measures to ensure that patients/LARs are fully apprised of participation-in-treatment and informed-consent rights before they are asked to give consent for any medication or treatment; (8) the institution agreed to distribute certain VOPA publications to all existing patients and LARs, and to all newly admitted patients and newly appointed LARs as they were admitted or appointed; (9) the institution revised policies and procedures to create a fail-safe system to ensure that future refusals or irregularities of consent to medication will be caught and dealt with appropriately before the consent is relied upon as authority to administer medication to patients; (10) institution policies and procedures were revised to establish a fail-safe system to ensure that physicians discuss contemplated medications and treatments with patients (and LARs as applicable) and satisfy all informed consent requirements before the patient/LAR is asked to sign a consent form; (11) all members of the institution's Medical, Social Work, and Psychology staff were required to attend in-service training on patient treatment planning and informed consent rights, and on the policy and procedure changes described above; and (12) the director of the institution issued a formal apology to the patient and her LAR.

* LAR forms are used to appoint an alternate decision maker when an individual is found to lack capacity to make his/her own decisions about treatment and information disclosures.

Priority 5: Special Education Advocacy and Legal Representation

GOAL 1: To protect the legal rights of and represent the interests of students with mental illness who are receiving special education services and supports in an inappropriate placement.

Indicator was: **X** Met /_/Partially Met/Continuing /_/Not Met

VOPA efforts in this area involved a 16 year-old female student with mental illness who required homebound instruction. Despite her parents persistent efforts at self-advocacy, the school district failed to assign a teacher for two months. When the parents involved VOPA, the school district immediately provided a teacher to instruct the homebound student. The family reports no further problems in obtaining required services from the school district. Although no case was formally opened here, the student received quality PAIMI services and by all reports, everyone is highly satisfied.

Other PAIMI Activities

1. VOPA staff participated monthly in the Mental Health Planning Council.

2. Virginia's Mental Health Planning Council represents consumer, family, and advocacy interests. Public Law 102-321 states explicitly that the Council members' role encompasses active advocacy for a more responsive service system and assistance in the monitoring, implementation and oversight of service system objectives of Virginia's Mental Health Plan. Council members advocate for the continuing development and expansion of a comprehensive community-based service system for Virginia's priority mental health populations -- adults with a serious mental illness, children and adolescents with a serious emotional disturbance, and children at risk of developing a serious emotional disturbance. The Council is especially interested in assuring that mental health consumers in Virginia receive quality care, case management services, and housing services. The Council is committed to assuring that the provision of these services is coordinated among agency providers (Taken from DMHMRSAS website).

3. VOPA staff also participated in the Adult Services Committee (a committee of the Virginia Mental Health Planning Council). The Adult Services Committee has primary responsibility to identify service priorities including addressing the various criteria in the annual Mental Health Plan. The Committee will become informed regarding the statewide system of publicly funded services for adults with serious mental illness and work with Department staff to develop priorities, goals and objectives, indicators and targets (Taken from DMHMRSAS website).

4. In addition, VOPA staff participated in the DMHMRSAS Advisory Council for Services to People Who Are Deaf, Hard of Hearing, Late Deafened and Deaf-Blind. Their mission is to provide the DMHMRSAS support, consultation, and technical assistance regarding comprehensive mental health, mental retardation, and substance abuse services for persons who are deaf, hard of hearing, late deafened, or deafblind. Meetings were held quarterly and a VOPA staff served as the elected secretary.

5. VOPA tracks and monitors relevant legislation each year. This includes commenting on proposed bills and providing research and information to advocates and legislators. This effort includes legislation relevant to PAIMI and individuals with disabilities who may be served by PAIMI.

SECTION III. INDIVIDUAL PAIMI CLIENTS

Provide the number of individual PAIMI clients for the categories that follow. Count a client only once during each fiscal year reporting period (even if the client returned for services many times of if many intervention strategies were provided - they are only counted once). Include individuals carried over from the previous year. Do not include individuals represented as part of a group or a legal class action, and individuals who receive only information or referral services.

A. Number of Individual Clients Served with PAIMI Funds

1. Number of clients receiving advocacy at start of fiscal year. Total **52**

2. Number of new/renewed clients represented during fiscal year. Total **93**

Total **145**

3. If program income or carryover was used to supplement the P&A allotment for the reporting period, estimate the number of individuals served as a result of carryover program income dollars this fiscal year.

   There was no program income in the PAIMI program. Each year, VOPA carries over a certain amount of its previous year's grant award. All available funds are utilized to support advocacy, representation, training and other program activities. Funds are not allocated by client as most of the cost of advocacy services is in the form of staff salaries. It is not possible for us to determine the number of clients served with carry-over vs. current year income.

4. The number of individuals who requested individual advocacy and who were eligible for services under the PAIMI Act [42 U.S.C. 10801 et seq.] but not 'served' within 30 days of initial contact due to insufficient PAIMI funding or non-priority issues (include individuals who received other services such as information and referral in-lieu): Total **130**

5. Identify populations, advocacy issues and activities (systemic, legislative, educational, training, etc.) that will need to be addressed in the future:

   a) VOPA will continue to take a larger, and more involved role, serving individuals with mental illness who are ready for discharge from state institutions but who have not been appropriately discharged or received appropriate discharge planning.
   b) Virginia has many new immigrant populations that are probably not being served or are underserved due to cultural and language issues.

B. Number of Case Problems of Individual Clients

Total **196**

[*The number may be higher than the total number of clients served by the P&A because each client may have more than one presenting problem to be addressed].

C. Age of Individual Clients

Age of Individual Clients	
0 – 4	0
5 – 20	14
21 – 59	117
60 – 64	3
65 and Over	8
Unknown	3
Total Clients	**145**

D. Gender of Individual Clients

Gender If Individual Clients	
Male	91
Female	54
Total Clients	**145**

E. Ethnic/Racial Background of Individual Clients [The data in this category is self-reported.]

Ethnicity/Racial Background	
American Indian or Alaska Native	2
Asian	3
Black or African American	33
Hispanic/Latino	2
Native Hawaiian or Other Pacific Islander	0
White	103
Information Not Provided	2
Total	145

F. Clients Living Arrangements at Intake

Clients Living Arrangements at Intake	
Independent	13
Parental or other Family Home	7
Community Residential Home (e.g., supervised apartment, semi-independent, halfway house, board & care, Care, small group home 3 or less)	5
Foster Care	0
Nursing Home(includes ICF, SNF, ICF/MR, etc.)	4
Psych wards of general hospitals (public or private) or their emergency rooms	0

Public (State Operated) Institutional Living Arrangement (e.g., hospital treatment center/school or large group home more than 3 beds)	85
Private Institutional Living Arrangement (e.g., hospital or treatment center, school or large group home more than 3 beds)	10
Legal Detention/Jail/Detention Center	7
Prison	13
Homeless	1
Federal Facility (List)	0
Total Client Cases by Living Arrangement	145

SECTION IV. CASE COMPLAINTS/PROBLEM AREAS OF INDIVIDUAL CLIENTS

Major complaints/problem areas presented by PAIMI clients were addressed through the provision direct client services which are listed in the following charts. Enter the number of complaints addressed by the PAIMI program on behalf of clients in the last fiscal year. Since many clients received PAIMI assistance on more than one complaint, the total number of complaints may exceed the served.

A.1. ALLEGED ABUSE: Number of Complaints/Problem Areas of Alleged Abuse:

Areas of Alleged Abuse	Outcome	# of Complaints From Closed Cases Only
a. Inappropriate or excessive medication	A=5; B=1;C=1; D=3; E=6	13
b. Inappropriate or excessive physical restraint, isolation or seclusion	A=1; E=3	5
c. Involuntary medication	A=1;D=1; E=1	2
d. Involuntary ECT	0	0
e. Involuntary aversive behavioral therapy	0	0
f. Involuntary sterilization	0	0
g. Failure to provide appropriate mental health treatment	A=5; C=2; D=1; E=4	12
h. Failure to provide needed or appropriate treatment for other serious medical problems	A=3; C=2; D=1; E=3	11
i. Physical assault	E=2	3
j. Sexual assault	E=1	2
k. Threats of retaliation or verbal abuse by facility staff	A=3; C=1; D=2	4
l. Coercion	E=1	1
m. Financial exploitation	E=1	1
n. Other. **Please describe on a separate sheet. This number should be less than 1% of the total # of abuse complaints. Make every effort to report within the above categories.	0	0
TOTAL (Sum of a. - n.)	55	54

A.2. Complaints Disposition: For closed cases, provide the numbers of abuse complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined Not to Have Merit on Investigation **7**
b. # of Complaints/Problems Withdrawn or Terminated by Client **4**

c. # of Complaints/Problem Favorably Resolved in Client's Favor **43**
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor **0**
e. Total Number of Complaints/Problem Addressed From Closed Cases **145**

ABUSE OUTCOME STATEMENT
For each area of alleged abuse, choose one or more outcome statements that either best described or related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the above table A.1.
A. Persons with disabilities whose environment was changed to increase safety or welfare.
B. Positive changes in policy, law, or regulation re: abuse in facilities (describe facility where impact was made).
C. Investigations of abuse by the P&A.
D. Validated abuse complaints that have favorable resolution as a result of P&A intervention.
E. Other indicator of success or outcome.

B. ALLEGED NEGLECT.

1. Number of Complaints/Problem Areas of Alleged Neglect: Failure to Provide For Appropriate.

Areas of Alleged Neglect	Outcomes	# of Complaints From Closed Cases Only
a. Admission to residential or inpatient care facility	0	0
b. Transportation to or from treatment facility	0	0
c. Mental health diagnostic or other evaluation (does not include treatment)	F=3	3
d. Medical (non-mental health related) diagnostic or physical examinations	0	0
e. Personal care (e.g., personal hygiene, clothing, food, shelter)	A=1;B=2;F=7	10
f. Personal safety (physical plant and environment)	A=1;F=1	2
g. Personal safety (client-to-client abuse)	0	0
h. Written treatment plan	0	0
i. Rehabilitation/vocational programming	A=1	1
j. Discharge planning	B=2;D=19;E=2;F=14	37
k. Release from institution	0	0
l. Other. [Please describe on a separate sheet. This should be less than 1% of total neglect complaints. Make every effort to report within the categories identified above.	0	0
TOTAL (Sum of a -l)	53	53

B. 2. Complaints Disposition: For closed cases, provide the total number of neglect complaints or problem areas for each disposition category.	
a. # of Complaints/Problems Determined upon Investigation Not to Have Merit	6
b. # of Complaints/Problems Withdrawn or Terminated by Client	2
c. # of Complaints/Problem Resolved in Client's Favor	45
d. # of Complaints/Problem Not Resolved in Client's Favor	0
e. Total Number of Complaints/Problem Addressed From Closed Cases. (Sum of a-d Should Equal the Total # of Complaints in Table B.1.)	53

NEGLECT OUTCOME STATEMENT
For each area of alleged neglect, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column in table B.1.
A. Investigations of neglect with P&A involvement.
B. Validated incidents of neglect by type.
C. Positive changes in policy, law, or regulation regarding neglect in facilities (describe facilities).
D. Persons with disabilities discharged consistent with their treatment plan after P&A involvement.
E. Persons with disabilities who had treatment plan that met selected criteria as a result of P&A involvement.
F. Other outcomes as a result of P&A involvement.

C. ALLEGED VIOLATION OF RIGHTS

1. Number of Complaints/Problem Areas on Protection of Rights:

Areas of Alleged Rights Violations	Outcome	# of Complaints from Closed Cases Only
a. Discrimination in housing	A=1;B=2;D=1	3
b. Discrimination in employment	0	0
c. Denial of financial reimbursements or entitlements (e.g., SSI, SDI, Insurance)	B=1;D=2	3
d. Problems with guardianship/conservatorship	B=1; D=1	2
e. Denial of information about rights protection or legal assistance	B=6;D=5	11
f. Denial of privacy (e.g., right to congregate, make/receive telephone calls, receive mail)	A=1	1
g. Denial of recreational opportunities (e.g., grounds access, television, smoking)	A=1;B=1	2
h. Denial of visitors	0	0
i. Denial of access to records/correction of records	A=2;B=2;D=1	3
j. Breach of confidentiality of records (e.g., failure to obtain consent to disclose)	0	0
k. Failure to obtain informed consent (may overlap with Involuntary treatment)	A=1;B=3;D=2;E=1	5
l. Failure to provide education (consistent with IDEA and state requirements)	A=1;B=1	2
m. Problems with advance directives	0	0
n. Denial of parental/family rights	0	0
o. Problems with consumer finance issues	0	0
p. Problems with immigration	0	0
q. Problems with criminal justice issues	0	0
r. Denial of community habilitation services	0	0
s. Problems with health insurance/managed care	0	0
t. Other (accessible jail cells)	B-1	1
TOTAL (Sum of a. - t.)	38	33

C. 2. Complaints Disposition: For closed cases, provide the number of rights violations complaints or problem areas for each disposition category.	
a. # of Complaints/Problems Determined Not to Have Merit on Investigation	1
b. # of Complaints/Problems Withdrawn or Terminated by Client	0
c. # of Complaints/Problem Favorably Resolved in Client's Favor	32

d. # of Complaints/Problem Not Favorably Resolved in Client's Favor	0
e. Total Number of Complaints/Problem Addressed From Closed Cases.	33

VIOLATIONS OF RIGHTS OUTCOME STATEMENT
For each of the areas of alleged violation of rights, choose one or more outcome statements that best describes or is related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the table above.
A. Persons with disabilities served by the P&A who's "rights" were restored as a result of P&A intervention.
B. Persons with disabilities whose personal decision making was maintained or expanded as a result of P&A intervention.
C. Policies or laws changed and other barriers to personal decisions making eliminated as a result of P&A intervention.
D. Other outcomes as a result of P&A involvement.

D. INTERVENTION STRATEGIES TO ADDRESS INDIVIDUAL CLIENTS

Complaints/Problems Areas: Enter the number of intervention strategies used to address each client complaint/problem area. A client may have more than one complaint and each complaint may require more than one intervention strategy. The total number of intervention strategies may exceed the total number of clients served.

Intervention Strategies	Outcome	Number
1. Short Term Assistance	*	56
2. Abuse/Neglect Investigations	*	4
3. Technical Assistance	*	28
4. Administrative Remedies	*	13
5. Negotiation/Mediation	*	44
6. Legal Remedies	*	139
TOTAL # of Invention Strategies [Add items 1. - 6.]		284

* VOPA cannot complete the "Outcome" column related to intervention strategies. We track only Case Problem Areas outcomes. We remain unable to track outcome by intervention strategy. This does not seem to be a feasible requirement as most cases involve multiple intervention strategies and the result would be a duplicative count. It is unclear how the requirement to track outcomes by intervention strategy could be met. VOPA would welcome exploring this further.

E. DEATH INVESTIGATION ACTIVITIES

1. Number of deaths in residential facilities for individuals with mental illness reported overall, throughout the State. See table below for more details. **59**

2. Number of deaths in residential facilities for individuals with mental illness investigated by the PAIMI program. **4**

The following examples demonstrate VOPA's involvement**.**

a) An investigation involved the sudden and unexpected death of a 27 year-old woman (TS) at an adult foster care facility. The death was reported to VOPA by a family member. TS had been removed from her home, separated from her husband, and placed in the adult foster care facility due to concern over her safety and her

husband's inability to care for her. She was discovered unresponsive in her bed only six days after admission to the adult foster care facility. VOPA obtained records from the local Community Services Board (CSB) and other care providers. The adult foster care facility failed to respond to numerous requests for records. VOPA filed a complaint in the U.S. District Court for the Western District of Virginia seeking injunctive relief to compel the facility to provide the requested records. VOPA and the facility subsequently entered into a settlement agreement whereby the parties filed a joint motion with the Court for a consent decree and permanent injunction by the terms of which the facility provided VOPA with access to records and staff. Records were also obtained from TS's primary care physician. In addition, a copy of the death certificate was obtained from the Office of Vital Records. No autopsy was performed in this case and death was attributed to "natural causes". VOPA conducted interviews of adult foster care facility staff, CSB staff, and the attending physician who signed the death certificate. The report of the police investigation, the DMHMRSAS licensing report, and DMHMRSAS human rights investigation into the death were obtained and reviewed. VOPA determined that the licensing investigation was adequate and required the providers and the CSB to take appropriate corrective action.

b) Another investigation involved the death by suicide of a 51 year-old man (MB) while a patient at a state mental health institution. MB was on a Not Guilty by Reason of Insanity status. He was found unresponsive on the floor of his bedroom with a sheet around his neck at 6:30 a.m. Attempts at resuscitation were unsuccessful. MB was last seen alive when checked by staff on routine rounds at 4:45 a.m. Per the institution's report, this time period exceeds hospital policy for routine observation of patients. MB had previously attempted suicide by jumping off a highway overpass four months prior to this hospitalization. (He sustained a fractured femur and pelvis as a result of that incident.) MB was not under special observation at the time of his death. An initial review of the record of care and treatment indicates that MB engaged in what appears to have been preparations for a suicide attempt or rehearsal 20 days prior to his successful suicide. Following that incident, he was placed on 1:1 staff observation for one day and 15 minute staff checks for three days. The hospital's internal investigation indicates that staff routinely failed to conduct the requisite safety checks of patients in general. VOPA also reviewed security videotapes and spoke with staff. VOPA determined that the facility took the appropriate corrective action in this case including ensuring appropriate staffing and supervision levels.

c) This investigation involves the death of a long-term patient (AD) of a state mental health institution. The cause of death was gangrene of the large intestine. During the investigation, VOPA reviewed medical records and reports from both the institution and the hospital where subject was taken after his condition became critical. VOPA also interviewed selected institution personnel and studied the autopsy report and related documents. A medical expert was retained to review the patient's records and to render an opinion of the medical care the institution's professional staff had provided. The expert concluded that the institution failed to meet community standards of medical practice in following up on abnormal laboratory findings and in detecting and obtaining treatment for the patient's developing, ultimately fatal condition. VOPA concluded that the institution's failures deprived the patient of opportunities to have his condition detected early enough for further diagnostics and treatment options to have been explored. This deprivation significantly diminished AD's chance of survival, and thereby subjected him to an increased risk of injury or death. Therefore, VOPA concluded that institution's failures met the legal definition of neglect. A draft report has been prepared by VOPA and approved by the expert. It is currently under consideration for publication.

SECTION V. INTERVENTIONS ON BEHALF OF GROUPS OF INDIVIDUALS

A. Summary Information

Type of Invention	Potential # of individuals impacted	Concluded Successfully	Concluded Unsuccessfully	On-going
Group Advocacy - non Litigation Stonewall Jackson Hotel Project	Approximately 80		Concluded due to National Park Service's action	
Investigation (Other than Death) State mental health	287	Yes		

institution				
Other: Litigation Veterans Administration	Approximately 80	Yes		
Total	447			

This table captured information on how the P&A program used its Federal funding or program income for non-individual client services. This information was not reflected in previous sections of this report. The activities reported in this table should be linked to the priorities for this fiscal reporting period. The sub-categories listed in the left column of the table (and the numbers for each category) should relate to the narrative section that follows.

1. One ex-resident committed suicide soon after he moved (it is unclear whether the move was directly responsible for this). During VOPA's investigation, staff discovered that the City of Staunton was involved in the planned renovations, and that a substantial portion of the funding would come from a HUD Community Development Block Grant and associated tax benefits to a corporate partner. VOPA took the position that HUD displacement regulations required the partnership to construct or otherwise replace, on a unit for unit basis, the low-income housing units lost by the former SLJ residents. VOPA joined forces with a Legal Services Organization (LSO) with extensive experience with HUD regulatory issues. Under the agreement, VOPA located and recruited ex-SJH residents, while the LSO handled most of the legal work. Settlement negotiations were begun with the City of Staunton, with various proposals advanced as to how the replacement housing requirement could be satisfied and all potential plaintiffs otherwise bound by a settlement. However, all this ground to a halt at the end of August, when the National Park Service (NPS) denied the Staunton Industrial Development Authority's (SIDA) application to de-certify an adjoining building as a historic structure (the renovation project would require this building to be razed). SIDA appealed the decision. If upheld, the NPS ruling would effectively end both the project and VOPA's bid to maintain the number of housing units available to Staunton/Augusta County area residents with mental disabilities, because the SJH renovation would no longer qualify for the HUD grant.

2. VOPA published its follow-up investigation into the use of Seclusion and Restraint in a state mental health institution. VOPA's initial investigation and report found that the institution did not comply with federal, state, or its own standards in its use of seclusion and restraint and had, too often, improperly and inappropriately used seclusion and restraint methods. In its follow-up investigation, VOPA attempted to ascertain whether the institution had improved its usage of seclusion and restraint methods. VOPA found that, while the institution seems to have decreased its inappropriate use of seclusion and restraint, its aggregate usage of the methods had increased and it, still, if less frequently, inappropriately used seclusion and restraint methods. As a result of the report, the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) made changes to the way it uses seclusion and restraint and has pledged to work with VOPA to reduce, with an eye toward eliminating, its use of these methods.

3. VOPA v. Hunter Holmes McGuire Medical Center challenging the refusal of Hunter Holmes McGuire Medical Center (a Department of Veterans Affairs hospital) to grant VOPA access to the facility and psychiatric patients. A hearing was held August 4, 2003, during which VOPA's motion for preliminary injunction was denied. The Court asked the parties to try to work out an agreement. A pretrial conference conducted August 21 and the parties began the discovery process. A settlement conference was held under the supervision of a federal magistrate judge on September 9. On September 11, 2003, the parties entered into a settlement agreement. By the terms of the settlement agreement, the McGuire Medical Center will permit the posting of information regarding VOPA and will provide patients in its mental health unit with brochures containing information about the protection and advocacy services available from VOPA and how to contact VOPA to request services. The Medical Center has also agreed to permit patients from the mental health unit to attend rights clinics presented by VOPA attorneys/advocates on a quarterly basis. Additionally, VOPA will have opportunities to provide annual training to Medical Center personnel regarding the function of VOPA and the rights of patients under the PAIMI Act. VOPA advocated for individuals who lost their home when the primary source of post-discharge housing for persons with mental disabilities in the Staunton/Augusta County area (Stonewall Jackson Hotel/ SJH) was shut down for the planned renovation into an upscale hotel and conference center. Because SJH represented the lion's share of placement resources in the area, many of its residents were moved to what they considered to be less desirable and less integrated placements (*e.g.* adult homes in isolated rural areas, distant placements, and in at least one instance, a homeless shelter.)

SECTION VI. NON CLIENT DIRECTED ADVOCACY ACTIVITIES

A. Individual Information and Referral (I & R) Services: Total Number 11,227

Topic	Date	Audience	Number in Attendance
Human Rights Regulations	10/15/02	Consumers, Hatcher Center, Danville, VA	16
VOPA Overview	10/31/02	Healthcare Professionals, Roanoke, VA	35
Introduction to VOPA	11/02/02	National Federation for the Blind Annual Conference, Spotsylvania, VA	70
Introduction to VOPA	11/11/02	Roanoke Valley Chapter of NAMI, St. Mark's, Roanoke, VA	41
Virginia Mental Health and the Law	12/06/02	Mental Health Professionals, Health Education Network, Richmond, VA	200
Treatment Rights of Children and Adults	12/06/02	Mental Health Professionals, Health Education Network, Richmond, VA	200
Olmstead: Your Right, Your Time, Your Chance	12/13/02	Consumers, Advocates, Family Members; Endependence Center, Hampton, VA	100
Making the I&R Standards Real	01/09/03	I&R Staff, NAPAS/ATTAC Program Management Conference, San Diego, CA	25
Networking with Non-P&A Providers	01/11/03	I&R Staff, NAPAS/ATTAC Program Management Conference, San Diego, CA	18
Enhancing Quality Assurance within Your I&R Program	01/11/03	I&R Staff, NAPAS/ATTAC Program Management Conference, San Diego, CA	20
VOPA Overview	01/14/03	Virginia Association for Area Agencies on Aging, Richmond, VA	20
VOPA Overview	01/29/03	Chesterfield Community Services Board, Richmond, VA	20
Introduction to VOPA and PAIMI	02/20/03	Catawba Local Human Rights Committee, Catawba, VA	12
VOPA Overview and Move Toward Community-Based Services	02/20/03	Prince William County Committee of 100	38
VOPA – Who We Are, What We Do, How We've Changed	03/11/03	Northern Virginia Mental Health Institute Advisory Council	36
VOPA Overview	03/20/03	Staff, Department of Mental Health, Mental Retardation and Substance Abuse Services, Richmond, VA	100
Introduction to VOPA and PAIMI	04/14/03	Martinsville/Henry County NAMI Chapter, Martinsville, VA	6
VOPA Overview and Its Role in Human Rights	04/25/03	State Human Rights Council, Richmond, VA	25
Virginia Mental Health and the Law	05/09/03	Mental Health Professionals, Health Education Network, Richmond, VA	125
Treatment Rights of Children and Adults	05/09/03	Mental Health Professionals, Health Education Network, Richmond, VA	200
Cultural and Linguistic Competence in Delivering P&A Services	05/29/03	NAPAS/ATTAC P&A/CAP Annual Conference, Washington, DC	30
Overview of Rights and Protection and Advocacy	05/31/03	Consumers/Advocates, Day for the Disabled, Norfolk, VA	100
HIPPA Privacy Rule	08/11/03	Staff, Virginia Office for Protection and Advocacy, Richmond, VA	26
Accessible Recreation: What the Law Requires	09/08/03	Virginia Society for Parks and Recreation Annual Meeting, Roanoke, VA	50

B. Education, Public Awareness Activities and/or Events.

1. Number of Education/Training Activities Undertaken **24**

2. Total number of persons trained (approximate) **1,513**

3. Information Dissemination Activities	Outcome	# of items
a. radio/TV appearances		0
b. newspaper articles (attach select articles	A	7
c. PSAs/videos/films/etc. aired		0
d. reports disseminated	A	1
e. publications disseminated	A, B	32,664*
f. Information about P&A disseminated (include general training /outreach or presentations not included in training activities	A, B	47,898*
g. Number of hits on Website	A	8,788
h. Describe other media activities	A, B	*

* During July 2002, DRVD was redesignated as an independent state agency and named the Virginia Office for Protection and Advocacy (VOPA). All publications and promotional materials were updated with the new name and logo and a mass distribution was made to ensure continued recognition of the purpose of our Office.

OUTCOME STATEMENT
For each area of non-client advocacy activity, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column above.
A. Persons who received information about the P&A and its services.
B. persons with disabilities (or their family members) who received education or training about their rights, enabling them to be more effective self-advocates.
C. Other outcomes as a result of P&A involvement.
D. Other outcomes as a result of P&A involvement.

SECTION VII. OTHER SERVICES AND ACTIVITIES

A. List groups (e.g., State Departments of Mental Health, other advocacy organizations, organized groups of recipients/former recipients of mental health services or family members of such individuals) with whom PAIMI worked cooperatively on activities:

Department of Mental Health, Mental Retardation and Substance Abuse Services and institutions
Local Human Rights Committees
Mental Health Planning Council
National Alliance for the Mentally Ill-Virginia and local affiliates
Partnership for People with Disabilities
Partners in Policy Making
Olmstead Plan Task Force and issue teams
Virginia State Independent Living Council
Department of Rehabilitative Services
Department of Medical Assistance Services
Office of the Attorney General
Advisory Council for Services to the Deaf, Hard of Hearing DeafBlind and Late-Deafened
Virginia Public Guardian and Conservator Advisory Board
Virginia Board for People with Disabilities
State Special Education Advisory Council
Virginia Workforce Council
Office of the Inspector General

HJ 199 Work Group
Medicaid Buy-In Work Group
Centers for Independent Living
Virginia Commonwealth University
Community Services Boards

Note: this list is not meant to be all-inclusive.

B. Describe outreach programs to increase the numbers of minority clients and educate minority constituencies about the PAIMI Program .

According to the 2000 US Census, Virginia's population is about 70% white and about 30% other races. The PAIMI caseload closely reflects this ratio. VOPA is sensitive to the need to explore more and better means of conducting outreach for minorities in all areas of our programs.

VOPA continues to work with its Advisory Council and staff to increase the number of members on Council and ensure diversity. However, a number of members resigned this year due to personal issues. Unfortunately, the Council is not ethnically diverse. Despite the efforts of staff and Council, recruiting new members has been difficult; the Council continues to recommend those volunteers who come forward as interested and committed to PAIMI rather than continue with vacancies while recruiting diverse volunteers.

C. Did your activities result in an increase of minorities in the following categories?

	YES	NO
Staff		**X**
Advisory Council		**X**
Governing Board		**X**
Clients		**X**

D. PAIMI Program Implementation Problems:

1. External Impediments:

   a) VOPA's right to access private facilities is continually questioned.

   b) The scope of VOPA's access to records (particularly those records that facilities may wish to characterize as "peer review" or "confidential personnel records") is still a source of hindrance, delay, and refusal to cooperate.

   c) VOPA continues to receive opposition from some DMHMRSAS facilities and from private facilities and providers. VOPA has had to threaten litigation on some occasions to get access to its clients.

2. Internal Impediments:

   a) Effective July 16, 2002, VOPA, formerly the Department for the Rights of Virginians with Disabilities, became an independent state agency, with a politically appointed Board of Directors. The Executive Director, who had previously been appointed by the Governor, had resigned in November 2001. The then Deputy Director became the Acting Executive Director. With the new designation, VOPA Directors and staff began sorting out what it means to be an independent state agency. In February 2003, the Acting Executive Director/Deputy Director accepted another position; one of the Managing Attorney's stepped forward to lead the agency during this transition, All staff had to temporarily accept additional responsibilities to ensure the on-going operation of the Office. In April 2003, a new Executive Director was hired. With a new designation and new leadership came organizational re-structuring. While, in the long run, this independent state agency status and new organizational structure will better serve our

clients, it has, in the short term, created some delays in representation and advocacy efforts.

b) VOPA lacks the clinical expertise on staff to adequately review and assess medical records/evidence. Additionally, medical/psychiatric experts who are willing to undertake record reviews are extremely difficult to locate.

E. Most Important Accomplishments: Please identify what you feel were the PAIMI' program's most important accomplishments in this fiscal year:

- The publication of the Olmstead Plan
- Successful litigation in the DPCSB case
- The McGuire Veterans Administration Hospital case
- Report on Seclusion and Restraint in specified state mental health institution
- Report on the Neglect of SH
- With only three staff assigned to the program, VOPA maintained an effective presence at the state mental health institutions

F. Technical Assistance Recommendations: List Recommendations for future PAIMI Program Federal Technical Assistance Activities.

VOPA would like to pursue awareness of the current PAIMI Program Federal Technical Assistance Activities**.**

SECTION VIII. ACTUAL PAIMI BUDGET/EXPENDITURES FOR FY 2003

PAIMI Program Personnel			
Position Title	**Annual Salary**	**% of Time Charged to PAIMI**	**Costs billed to PAIMI**
Lead Service Coordinator	$40,000	20%	$8,000
Staff Attorney	$50,000	100%	$50,000
Service Coordinator	$37,577	29%	$10,897
Service Coordinator	$26,451	20%	$5,290
Staff Attorney	$42,762	100%	$42,762
Receptionist	$15,825	23%	$3,640
Deputy Director	$66,734	25%	$16,684
Managing Attorney	$66,762	50%	$33,381
Administrative Assistant	$26,894	20%	$5,379
Staff Attorney	$44,152	100%	$44,152
Program Operations Coordinator	$43,445	35%	$15,206
Sub-Total	$460,602	47%	$235,390
++Vacant positions	0		
Volunteer positions	0		

TOTAL # OF POSITIONS	$460,602	47%	$235,390

ACTUAL PAIMI BUDGET/EXPENDITURES FOR FY 2003

CATEGORIES	**COST**
Fringe Benefits (PAIMI only)	$ 57,081
Travel Expenses (PAIMI only)	$ 21,526
SUBTOTAL	$ 78,607

EQUIPMENT - TYPE (PAIMI ONLY)	**COST**
Computer	$ 1,996
Reference	$ 1,412
Voice/Data Transmission	$ 84
Office	$ 47
Electronic/Photographic	$ 144
SUBTOTAL	$ 3,683

SUPPLIES - TYPE (PAIMI ONLY)	**COST**
Office	$ 3,307
Stationary	1206
Gasoline	44
Data Processing	786
Educational	350
SUBTOTAL	$ 5,693

ACTUAL PAIMI BUDGET/EXPENDITURES FOR FY 2003

Contractual Costs (including Consultants) for PAIMI Program Only

Position or Entity	**Service Provided**	**Salary/Fee**	**Fringe Benefit Cost**	**Travel Expenses**	**Other Costs**
Legal Services	Contract Attorneys	$ 3,414			
Employment Agency	Temporary. Personnel	$ 7,272			
Information Systems	Database Design/Develop.	$ 1,750			
Expert Services	Medical	$ 15,675			
SUBTOTAL		$ 28,111			

Training Costs for PAIMI Program Only

Categories	**# of persons/Travel Costs**	**# of persons/Training Costs**	**# of persons/other expenses**	
Staff	7/$600	7/$1,866		
Governing Board	2/$375	2/$265		
Advisory Council	1/$204	1/$132		

Subtotal	$1,179	$2,263		

Other Expenses (PAIMI Program Only)	Costs
Shipping Services, Telephones, Organization Memberships/Publication Subscriptions,	$ 40,879
Printing, Equipment/Office Space Rentals, Furniture, Recruitment Expenses	
Indirect Costs	$ 48,136
	$ 89,015

ACTUAL PAIMII BUDGET/EXPENDITURES FOR FY 2003

Indirect Costs (PAIMI only): Does your P&A have an approved Federal indirect cost rate?		
X yes	no; If yes, what is the approved rate?	16%
TOTAL ALL COSTS (PAIMI only)		
$ 443,941		

INCOME SOURCES AND OTHER RESOURCES (PAIMI PROGRAM ONLY)	
PAIMI Program Carryover from the previous Federal Fiscal Year(s)** FY02	$ 381,542
Program Income	$ -
Interest on Lawyers Trust Accounts (IOLTA)	$ -
State	$ -
County	$ -
Private	$ -
Other (list)	$ -
Total of resources from all Sources	$ 381,542
** Please identify the carryover funds by Federal Fiscal Year, e.g., FY 2001, FY 2002.	